

**State Employee Benefits Committee
Tatnall Building, Room 112
Dover, Delaware 19904**

The State Employee Benefits Committee met December 11, 2017. The following people were in attendance:

Committee Members:

Mike Jackson, Director, OMB, Chair
Bethany Hall-Long, Lt. Governor
Saundra Johnson, DHR
Molly Magarik, Designee of DHSS
Mike Morton, CGO
Evelyn Nestlerode, Designee of Chief Justice, Administrator of Courts
Ken Simpler, OST
Trinidad Navarro, DOI
Jeff Taschner, DSEA
Kara Walker, DHSS
Keith Warren, Designee of Lt. Governor

Guests:

Brenda Lakeman, Director, Statewide Benefits Office (SBO)
Faith Rentz, Deputy Director, SBO
Lisa Porter, SBO
Andrew Kerber, DOJ
Matt Bittle, DE State News
Tom Brackin, DSTA
Victoria Brennan, CGO
Rebecca Byrd, The Byrd Group
Lisa Carmean, City of Milford
David Craik, Pensions
Cherie Dodge-Biron, DHR
Jacqueline Faulcon, DRSPA
Larry Gabbert, Pensioner

Guests (continued):

Leighann Hinkle, SBO
Rebecca Kidner, RB Kidner PA
Lucinda Lombardelli, PHRST
Jon McDowell, Retiree
Mary Kate McLaughlin, Drinker Biddle
Evan Miller, City of Milford
Regina Mitchell, OMB
William Oberle, DSTA
Paula Roy, DCSN
Bert Scoglietti, OMB
Anna Kelleher, OMB
George Schreppler, DCSN
Christine Schultz, PGS

Mike North, Aetna
Katherine Impellizzeri, Aetna
Carrie Schiavo, Delta Dental
Peg Eitl, Highmark
Lisa Mantegna, Highmark
Jennifer Mossman, Highmark
Pam Price, Highmark
Walt Mateja, IBM Watson Health
Steve Shelton, IBM Watson Health
Kevin Fyock, Willis Towers Watson
Chris Giovannello, Willis Towers Watson
Jaclyn Iglesias, Willis Towers Watson
Rebecca Warnken, Willis Towers Watson

Introductions/Sign In

Director Jackson called the meeting to order at 2:04 p.m. Introductions were made.

Approval of Minutes - handout

The Director entertained a motion to approve the minutes from the November 13th SEBC meeting. With a noted correction to Mr. Oberle's last name, Secretary Johnson made the motion and Controller General Morton seconded the motion. The motion carried.

Director's Report – Brenda Lakeman, Statewide Benefits Office (SBO)

Flexible Spending Account (FSA) – Enrollment ended November 17th

Final stats show 5,868 enrollments in the healthcare and 895 in the dependent care accounts for a total enrollment of 6,161 individuals, a 10% increase for 2018.

LabCorp is being added as a preferred lab for Aetna effective January 1, 2018 and will be listed on DocFind effective January 4th.

EGWP members who have prescriptions changing from preferred to non-preferred will be receiving letters.

CVS/Aetna – On December 3, 2017 a merger agreement was announced between CVS and Aetna whereby CVS will acquire Aetna. The transaction will take place mid-2018 if approved by the regulatory authorities. Details to be provided as received.

Spousal Coordination of Benefits Policy – handouts – Brenda Lakeman, SBO

A recap of the purpose and intent of this policy was provided. Changes to be effective May 1, 2018 if vote carries today.

FY19 Initiatives – handout – Willis Towers Watson Team (WTW)

Site-of-Steerage recommended changes for FY19 was reviewed showing the current copays with the recommended design copays for Basic Imaging, High Tech Imaging and Outpatient Lab to be effective July 1, 2018 if vote carries at today's meeting. Clarification on freestanding facilities versus hospital based facilities was provided. The same logic with copays that applied to high tech imaging was applied to basic imaging. Members who utilize the preferred site-of-care for imaging and lab services will not pay higher copays, in fact pay less for basic imaging services. WTW encouraged a review of the progress of these changes with the ability to revise if needed.

Centers of Excellence - COE recommended changes for FY19 include to move forward with a limited set of COE services (Orthopedic and Spine) with Highmark and Aetna and adopt recommended design for PPO and HMO plans effective July 1, 2018. In addition, it is recommended that a Request for Proposal (RFP) be conducted for a third party COE vendor to catalyze competition in the marketplace which may result in negotiations by Aetna and Highmark for more favorable pricing for orthopedic/spine services with existing OE facilities. Ms. Nestlerode asked for the number of COEs in the Philadelphia region. Dr. Walker asked about ensuring cost and quality information is provided to members. Mr. Taschner expressed concern with the COE proposal stating it has financial impact on members and seems to benefit the providers as this proposal steers members to COE facilities or it will cost the member more, plus the reduction in costs by facility is not shared and he does not support this vote.

Highmark and Aetna already have COE's outside of Delaware with a large portion of savings due to lower readmission rates and healthier outcomes due to higher quality. In Delaware, Aetna has one and Highmark is adding a COE, both for orthopedic/spine. Dialogue occurred around issuing a COE RFP available to the TPA's and those external plus a request to see data of what it costs when members go to these facilities outside of network, the dynamic to determine cost savings, quality of care and the need to be transparent. It was noted that a copay does not exist with a Bariatric COE yet does with Orthopedic and Spine. Aetna and Highmark define the criteria within their COE networks. A suggestion for public workshops be provided to members to review these changes. Lt. Governor circled back to the need of preventive care to avoid spines and hips being replaced.

Active Enrollment was presented at the previous meeting and discussion continued on the requirement in FY19 for SEBC to select a default plan if a member does not select a plan during Open Enrollment. The proposal was made to actively engage employees to 1) review and update their contact information, 2) access the myBenefitsMentor online tool, (both actions available in one place within Employee Self-Service (ESS)) and 3) finally click either No Changes or Have Changes in Benefits Enrollment in ESS. Data will be tracked to determine completion. Employees will be not be defaulted to a define plan this year but a strong message will be provided to employees regarding engagement in this process to determine different steps to be taken in 2019 if needed. SBO has been aggressive in getting out into the member population. Mr. Simpler requested a post OE survey to employees to ascertain why they did not make benefit plan choices recommended and viewed through myBenefitsMentor. SBO's goal is to target those members who do not engage. One possibility is to set up computer labs to show employees how the plans can save them money. Secretary Johnson shared that DHR will be conducting the onboarding differently to dedicate time to benefits for new employees with the goal to start within the next six months.

Public Comments

None

Motions

Director Jackson entertained a motion to adopt the SCOB policy and additions as distributed. Acting Secretary Johnson made the motion and Lt. Governor seconded the motion. The motion carried.

The Director requested a motion to adopt the recommendations for the Site-of-Care Steerage for outpatient lab and imaging as reviewed. Acting Secretary Johnson made the motion and Secretary Walker seconded the motion. The motion carried with an effective date of July 1, 2018.

A third motion was solicited by the Director to adopt the recommendations for the Centers of Excellence as discussed including monitoring of quality metrics effective July 1, 2018. Secretary Walker made the motion and Acting Secretary Johnson seconded the motion, with one member opposing. The motion carried.

Financials - handouts - Willis Towers Watson Team (WTW)

September 2017 Fund & Equity (F&E) Report

A reduction in utilization across both plans is seen, however not expected to continue as Aetna estimates four months to stabilize the transition in their claims and premiums. Claim liability is at \$59M, slight increase driven by migration into the Aetna plan. Projections are refreshed every six months. Fund Equity balance is at \$125.6M.

FY18 Q1 Reporting

Overall medical and prescription drug cost for the period of July 1 through September 30, 2017 is \$179.8M, or 11.6% below budget, resulting in a surplus of \$23.6M or 8.2% decrease per employee. Inpatient increased 8% while the number of admits decreased 5%. Chronic conditions decreased for most categories, diabetes increased 3% over the prior period and antidiabetic agents (insulins etc.) remained among the costliest therapeutic class of drugs. Prescription drug average cost/day decreased 2% while specialty prescription as a percentage of total prescription spend increased from 29% to 33%. Following a significant shift in enrollment into Aetna HMO for FY18, reporting shows inpatient and outpatient levels decreased in Q1, though it is anticipated these metrics will return to expected levels as the HMO plan matures.

Budget Projection Recast

Historical GHIP cost increases were illustrated along with marketplace trend survey data. Medical and pharmacy gross claims per employee per year from Q1FY16 through Q1FY18 show FY18 is favorable. An overview of the health care cost trend shows the marketplace at 6 to 7% for medical and 10 to 12% for pharmacy. WTW recommends continuing to adjust trend assumptions based on GHIP-specific historical trend performance and external environment factors. National medical trend for Medicare-eligible populations running lower than active/pre-65 retiree populations, with costs increasing 3-4% annually. External survey sources show national pharmacy trend in the 8 to 10% range for Medicare-eligible populations. With specialty drugs having a significant impact on this group, it is recommended to set trend in the 10 to 12% range. The recommended health care cost trend assumptions were reviewed. The health care budget projections show the FY18 recast projected cost of \$790.2M representing a 1.1% decrease driven by favorable claims experience in Q1 FY18. FY19 projected cost of \$843.2M is a 6.7% increase over FY18 recast and suggests a 4.3% increase in budget rates over current FY18 if no surplus is used and before implementing Site-of-Care Steerage. A review of the sensitivity analysis for FY18 recast and FY19 projection illustrated a range of assumptions with varied weighting for experience periods and trend factors. This allows the SEBC to choose to be more or less conservative in setting the FY19 GHIP budget by selecting an alternative set of assumptions. The health care trend variability analysis provides statistical confidence intervals to better quantify volatility and address risk tolerance concerns. At the March 6, 2017 SEBC meeting, it was approved to set minimum reserve at the 97% confidence interval with intent to review this amount annually.

Long Term GHIP Planning (FY19 Planning)

The GHIP long term health care cost projections with no program changes were updated with FY18 Q1 that reflects a decrease in FY19. Each 1% for FY19 is worth \$9 to \$10M. Similar data noted with program changes reflect FY20 with a 2% premium increase. Director Jackson added \$50M would be needed even after 2% premium increase and program changes to close the gap between operating and revenue in FY20. Monthly rates and employee/retiree contributions with a 2% increase were shown for FY2019 for illustrative purposes. Treasurer asked for the weight or value of healthcare in the employee's wages. Future groundwork to support GHIP members with interventions that will drive decision-making and behavior change to engage members was presented in four focal points to be implemented FY19 and beyond. SBO to check if tracking can be applied when member's emails are opened, read, etc. Ms. Magarik added

Initiative 2 on the DHSS Health Care Spending Benchmark is a trend target, not a cap. Data would be used to set the target in statute, with the legislature body to set that inflation point. Targeted opportunities for SEBC consideration were reviewed such as cost transparency. Included in next steps is for SEBC is to look more closely at on-site or near-site clinics. Need to review goals and parameters to determine costs associated with clinic and then to determine what the funding would be for the clinics. Ms. Magarik shared clinics need to connect to DHIN to avoid fragmentation of care. Director Jackson added this planning needs to include goals, operating parameters and any architectural modifications. The design of an approach for decision making will consist of lengthy conversations to determine how to move forward.

Other items of interest to the SEBC to discuss in the next few meetings include WTW to relay to SEBC in short term (two to three years) where others have had success and the potential upside to change dynamics of healthcare. When considering raising premiums slightly, look at long term protections to mitigate larger spikes in the future.

The Director asked for any additional Public Comments.

Additional Public Comments

Bill Oberle, DSTA, shared when the Treasurer switched from Fidelity to Voya, it was done right such as meeting with DSTA membership. SEBC should use this as a model for health care. It is troubling that the TPAs appeared before the Health Task Force committee and informed the State they are being overcharged by the hospitals. Does SEBC have the authority to get that information from the TPAs as without that data moving forward, we cannot take a chunk out of the health care costs? The average member of the General Assembly lacks the knowledge of this health care cost dilemma so how does SEBC get this information which he believes is legally ours?

Other Business

None

Director Jackson requested a motion to adjourn the meeting. Controller General Morton made the motion and Ms. Magarik seconded the motion.

Meeting adjourned at 4:16 pm.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office